Form A19-1A (Rev. 5/91)	State of Washington **INVOICE VOUCHER**

Agency Use Only		
Agency No.	**Location Code**	**P.R. or Auth. No.**
303	**GR5**	

AGENCY NAME

Washington State Department of Health

DOH-CFH-CWP-WIC-NLS

VENDOR OR CLAIMANT

INSTRUCTIONS TO VENDOR OR CLAIMANT:
Submit this form to claim payment for materials, merchandise or services. Show complete detail for each item.

Vendor's Certificate: I hereby certify under penalty of perjury that the items and totals listed herein are proper charges for materials, merchandise or services furnished to the State of Washington, and that all goods furnished and/or services rendered have been provided without discrimination because of age, sex, marital status, race, creed, color, national origin, handicap, religion, or Vietnam era or disabled veterans status.

By_____

_____
(Title) **(Date)**

Social Security No.	**Received by:**	**Date Received:**

I hereby certify that I attended the following training:

Core WIC ☐ **New Nutritionist Orientation** ☐

Learning to Lead ☐ **New Coordinator Orientation** ☐

Other ☐ _____

Dates Attended:

I therefore claim the following travel expenses:

# of Breakfasts_____	# of Lunches _____	# of Dinners_____
Meal Allowance $_____	Meal Allowance $_____	Meal Allowance $_____
Total: $_____	Total: $_____	Total: $_____

Meals: ..... **$**_____

Lodging: (attach original receipt)..... $_____

Mileage: _____ X $.445 ..... $_____

Other: (describe clearly) _____..... $_____

TOTAL: $_____

Prepared by	**Telephone Number (360)**	**Date**	**Agency Approval**	**Date**

Doc. Date	**Pmt Due Date**	**Current Doc No.**	**Ref. Doc No.**	**Vendor Number**	**Vendor Message**	**Use Tax**	**UBI Number**

	Master Index					WorkClass	County	City/Town					
Fund	Appn Index	Master Index	Sub Obj	Sub Sub Obj	Org Index	Alloc	Budget Unit	MOS	Project	Sub Proj	Proj Phas	Amount	Invoice Number
	752	11260	EG	4112									

Accounting Approval for Payment	**Date**	**Warrant Total**	**Warrant No.**